

ASSESSMENT PLAN FOR AFC RESIDENTS

Michigan Department of Human Services
Office of Children and Adult Licensing

INSTRUCTIONS:

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Human Services and contains the information required by administrative rule and Section 3 (9) of Act 218, P.A. 1979, as amended.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process.
4. Use additional sheets if necessary and **PRINT CLEARLY**.

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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I. SOCIAL/BEHAVIORAL ASSESSMENT PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community	<input type="checkbox"/>	<input type="checkbox"/>	
B. Communicates Needs	<input type="checkbox"/>	<input type="checkbox"/>	
C. Understands Verbal Communication	<input type="checkbox"/>	<input type="checkbox"/>	
D. Alert to Surroundings	<input type="checkbox"/>	<input type="checkbox"/>	
E. Reads and Writes	<input type="checkbox"/>	<input type="checkbox"/>	
F. Tells Time	<input type="checkbox"/>	<input type="checkbox"/>	
G. Manages Money	<input type="checkbox"/>	<input type="checkbox"/>	
H. Follows Instructions	<input type="checkbox"/>	<input type="checkbox"/>	
I. Controls Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
J. Controls Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
K. Gets Along With Others	<input type="checkbox"/>	<input type="checkbox"/>	
L. Exhibits Self Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
M. Participates in Social Activities	<input type="checkbox"/>	<input type="checkbox"/>	
N. Smokes	<input type="checkbox"/>	<input type="checkbox"/>	
O. Appropriately Uses Alcohol/Drugs	<input type="checkbox"/>	<input type="checkbox"/>	

See Page 4 for Non-discrimination and ADA statement

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II. SELF CARE SKILL ASSESSMENT**PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		IF YES, Describe Needs and How The Will Be Met
	Yes	No	
A. Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
B. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	
D. Grooming (hair care, teeth, nails, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
E. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	
F. Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	
G. Walking/Mobility	<input type="checkbox"/>	<input type="checkbox"/>	
H. Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
J. Use of Assistive Devices (explain)	<input type="checkbox"/>	<input type="checkbox"/>	
K. Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	

III. HEALTH CARE ASSESSMENT**PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	<input type="checkbox"/>	<input type="checkbox"/>	
B. Special Diets	<input type="checkbox"/>	<input type="checkbox"/>	
C. Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
F. Susceptible to Hypothermia or Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	

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IV. SOCIAL AND PROGRAM ACTIVITIES PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	Explain How These Activities Will Be Provided or Encouraged
A. Participates in Religious Practice	<input type="checkbox"/>	<input type="checkbox"/>	
B. Participates in Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	
C. Adult Activity Program	<input type="checkbox"/>	<input type="checkbox"/>	
D. Senior Center	<input type="checkbox"/>	<input type="checkbox"/>	
E. Workshop or job	<input type="checkbox"/>	<input type="checkbox"/>	
F. School	<input type="checkbox"/>	<input type="checkbox"/>	
G. Hobbies/Special Interest	<input type="checkbox"/>	<input type="checkbox"/>	
H. Recreation	<input type="checkbox"/>	<input type="checkbox"/>	
I. Physical Exercise	<input type="checkbox"/>	<input type="checkbox"/>	
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)	<input type="checkbox"/>	<input type="checkbox"/>	
K. Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	

V. MEDICAL INFORMATION

Name of Primary Physician/Clinic		Telephone Number ()	
Primary Physician's Complete Address (Street Number and Name)	City	State	Zip Code

V. MEDICATIONS TAKEN AT TIME OF ASSESSMENT

Name of Medication	Who Prescribed	Dosage

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MEDICAL OR DENTAL FOLLOW-UPS NEEDED (i.e., check-ups, regular appointments, etc.)

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VI. RELEASE OF INFORMATION – RESIDENT OR LEGAL GUARDIAN SIGNATURE ONLY

“By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee’s staff, the responsible agency and the Michigan Department of Human Services, Office of Children and Adult Licensing, for the purpose of providing appropriate care to me and determining compliance with licensing rules.”

Signature of Resident or Legal Guardian	Date
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VII. OTHER INFORMATION

Comments/Special Instructions

VIII. ASSESSMENT PLAN COMPLETION

Date Assessment Plan Was Completed	Name(s) and Position(s) of Person(s) Who Completed Assessment
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IX. PLACEMENT OBJECTIVE

A. <input type="checkbox"/> Delay/prevent deterioration and movement to a more restrictive setting.
B. <input type="checkbox"/> Encourage movement to a less restrictive setting.

X. SIGNATURES

Signature of Resident or Designated Representative	Date	Signature of Licensee	Date
Signature of Responsible Agency (if applicable)	Date		

AUTHORITY: Act 218 P.A. 1979, as amended
COMPLETION: Voluntary
PENALTY: Violation of Administrative Rule and Act 218 P.A. 1979, as amended

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.